S. No. 300
M—10-47
v. 5-17-39
I 3906

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 28 1948

Registration District No. 146

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30051

Primary Registration District No. 3026

Registrar's No. 285

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0
Independence Sanitorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Fairmount Station, K. C. Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 543 Cedar, Rural 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROBERTS, Mrs. Mary A

3. (b) If veteran, name war No

3. (c) Social Security No. 487-26-8934

4. Sex Fem 1

5. Color or race Wh

6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife James Roberts

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased 3/2/1914
(Month) (Day) (Year)

8. AGE: Years 34 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Concordia, Kans. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business --

MOTHER FATHER

12. Name John Dugger 1

13. Birthplace Ky
(City, town, or county) (State or foreign country)

14. Maiden name Willa Belle Sandusky

15. Birthplace Ky 1
(City, town, or county) (State or foreign country)

16. (a) Informant James Roberts

(b) Address 543 Cedar, Kansas City, Mo.

17. (a) Burial (b) Date thereof 9/21/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director John P. Sheil

(b) Address

19. (a) 9-21-48 (b) [signature]
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18

year 48 hour P minute ____ M.

21. I hereby certify that I attended the deceased from Sept 16, 19 48 to ____, 19 ____;

that I last saw her alive on Sept 18, 19 48;

and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage — Duration 10 days

Due to Congenital Aneurysm of Circle of Willis

Due to ____

Other conditions (Include pregnancy within 3 months of death) ____

Major findings:
Of operations 0

Of autopsy Subarachnoid Hemorrhage Aneurysm of Circle of Willis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? ____ (e) Means of injury 0

23. Signature Ted W. Clark M.D. (M. D. or other)

Address Kansas City, Mo Date signed 9/19/48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John P. Sheil

Licensed Embalmer No. 3625

P. O. Address K 6 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.